

Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations:

Scope of Practice Review Committee Report on Interim Therapeutic Restorations (ITR) for Dental Hygienists

Jewel Mullen, MD, MPH, MPA, Commissioner 02/01/2012



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State of Connecticut

Department of Public Health

Report to the General Assembly

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Executive Summary

In accordance with Public Act 11-209, the Connecticut State Dental Association (CSDA) submitted a scope of practice request to the Department of Public Health to change the scope of practice for dental hygienists. CSDA submitted a scope of practice request to increase the scope of dental hygiene practice to include interim therapeutic restorations (ITR) with hand instruments in public health and institutional settings. The Department also received two additional scope of practice requests related to dental care and services: a request from the Connecticut Dental Hygienists Association (CDHA) related to advanced dental hygiene practitioners and a request from the Connecticut Dental Assistants Association (CDAA) related to expanded function dental auxiliaries. The Department made a decision to combine the scope of practice review committees due to the complexity of the issues and because the impacted parties are the same for all of the requests. The decision to combine the committees was supported by scope of practice review committee members. A separate report, however, is being submitted for each of the scope of practice requests as the issues are very distinct.

The scope of practice review committee reviewed and evaluated the CSDA's request to expand the dental hygiene scope of practice as well as subsequent written responses to the request and additional information that was gathered through the review process. Literature and other information reviewed and evaluated by the scope of practice review committee demonstrated that Interim Therapeutic Restoration (ITR) with hand instruments is a safe and effective procedure that should be included within the dental hygiene scope of practice, and would be particularly useful in the public health settings where dental hygienists are already treating patients who may benefit from this procedure. Evidence supports that the procedure is successful in slowing the disease process and buys additional time for the patient to get an appointment to see a dentist for more definitive care. It should be noted that practitioners must be careful in educating patients that ITR is not complete treatment and stress the importance of the need for follow-up care with a dentist. In addition, evidence supports the view that in most cases, providing an interim measure such as ITR is far better than simply allowing the decay to continue. ITR would also allow a hygienist to restore and prevent further decalcification and carries in young patients, uncooperative patients or patients with special needs when the placement of traditional dental restorative materials are not feasible. Studies are available that demonstrate that while ITR is not a definitive treatment, it may stabilize the diseased dentition for up to 4 years.

If ITR is added to the scope of dental hygiene practice, the practice act must also be clarified to include references to dental hygiene triage and diagnosis. It would be within the dental hygienist's discretion to triage the patient and determine whether ITR is appropriate at that time or whether an immediate referral to a dentist is required. Education and training related to the performance of ITR can certainly be incorporated into existing accredited dental hygiene education programs moving forward and an interim program could be developed by Connecticut's accredited dental hygiene programs or the dental school to allow currently licensed dental hygienists to gain competency in this procedure.

The scope of practice review committee did not identify any public health and safety risks associated with the request, provided the changes would be implemented in conjunction with the above recommended statutory revisions related to the dental hygiene practice act and educational programs are able to offer the necessary training. Evidence provided by the CSDA demonstrated that enactment of these changes has the potential to enhance quality and affordable health care in Connecticut and enhances the ability of the dental hygiene profession to practice to the full extent of its education and training.

The committee was not presented with draft statutory revisions for review. Should the Public Health Committee decide to raise a bill related to CSDA's scope of practice request, the Department of Public Health along with the pertinent organizations that were represented on the scope of practice review committee to review this request (CSDA and CDHA) respectfully request the opportunity to work with the Public Health Committee on revised statutory language.

Background

Public Act 11-209, <u>An Act Concerning the Department of Public Health's Oversight Responsibilities</u>
Relating to Scope of Practice Determinations for Health Care Professions, established a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

- Two members recommended by the requestor to represent the health care profession making the scope of practice request;
- Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and
- 3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an exofficio, non-voting member of the committee.

The Commissioner of Public Health was also authorized to expand the membership of the committee to include other representatives from other related fields if it was deemed beneficial to a resolution of the issues presented.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an

assessment of any public health and safety risks that may be associated with the request, whether the request my enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The Connecticut State Dental Association (CSDA) submitted a scope of practice request to increase the scope of practice of dental hygienists to include interim therapeutic restorations (ITR) with hand instruments in public health and institutional settings.

Impact Statements and Responses to Impact Statements

Written impact statements in response to the scope of practice request submitted by the CSDA were received from the Connecticut Dental Hygienists Association (CDHA) and the Connecticut Association of Endodontics (CAE). CDHA provided very specific comments and requested that a scope or practice review committee be established to review the request as it directly impacts the scope of practice of its members. While CDHA acknowledged the merits of ITR, they do not see implementation of this proposal as a solution to improving access but as another "band aid application" when comparing it to a more comprehensive approach such as the advanced dental hygiene practitioner. CDHA also expressed concern that patients may perceive ITR as complete treatment and that follow-up care is not indicated. CAE supports the proposal. CSDA submitted written responses to both the CDHA and CAE, which were reviewed by the scope of practice review committee.

Scope of Practice Review Committee Membership

In accordance with the provisions of Public Act 11-209, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by the CSDA. The Department received three scope of practice requests related to dental care and services: the request submitted by the CSDA, which is the subject of this report; a request from the Connecticut Dental Hygienists Association (CDHA) related to advanced dental hygiene practitioners; and a request from the Connecticut Dental Assistants Association (CDAA) related to expanded function dental auxiliaries. Because the issues are complex and the impacted parties are the same for all of the requests, the scope of practice review committees were combined. Committee members specific to this request included:

- 1. Two members recommended by the CSDA;
- 2. Two members recommended by the CDHA; and
- The commissioner's designee (chairperson and ex-officio, non-voting member).

Although the Connecticut Association of Endodontics submitted a written impact statement, they opted not to have specific representation on the scope of practice review committee.

Scope of Practice Review Committee Evaluation of Request

CSDA's scope of practice request included all of the required items identified in PA 11-209 as outlined below. Additional clarifying information was obtained during the review and evaluation of this request.

Health & Safety Benefits

CSDA identified the following health and safety benefits associated with implementing the scope of practice request:

Interim Therapeutic Restorations (ITR) may be used to restore and prevent further decalcification and caries in young patients, uncooperative patients, or patients with special health care needs, and when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed. Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth. The use of ITR has been shown to reduce the levels of carcinogenic oral bacteria in the oral cavity. The procedure involves removal of caries using hand instruments by hygienists with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as self-setting or resin-modified glass ionomer. ITR has the greatest success when applied to single surface or small 2 surface restorations. Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations.

Similar information was also provided by the CAE in support of this request.

Access to Healthcare

CSDA identified that implementation of the scope of practice request would have the following impact on access to health care:

Increasing the capacity of the dental delivery system with 1,300 dentists treating the Medicaid population does not increase utilization of dental services to the level of the population with the financial means to seek care. This is due to socioeconomic issues such as the ability of the parents of children to take time from work, arrange transportation, or valuing such services. In school based programs, these children do have access to care, mostly by hygienists, who see lesions that could be treated by this therapy. Due to the short and cost effective training period to teach this competency, it can have an immediate effect on the target population. Failure to implement such a change will continue the present status of care in schools and institutions across Connecticut.

Laws Governing the Profession

Chapter 379 of the Connecticut General Statutes governs the profession of dentistry. Chapter 379a of the General Statutes governs Dental Hygienists.

<u>Current Requirements for Education and Training and Applicable Certification Requirements</u>

Chapter 379 of the Connecticut General Statutes governs the profession of dentistry. Chapter 379a of the General Statutes governs Dental Hygienists.

Summary of Known Scope of Practice Changes

Multiple bills have been put forward to increase the scope of practice for dental hygienists to include new competencies, but none have passed within the last five years.

Impact on Existing Relationships within the Health Care Delivery System

CSDA identified that the implementation of this scope of practice request would have the following impact on existing relationships within the health care delivery system:

The request increases the scope of practice for dental hygiene to address the determined needs of the target population. This collaborative effort by organized dentistry and dental hygiene may improve the relationship between the organizations. The dental hygiene profession will be responsible for implementing the increased scope of practice in treating patients in public health and institutional settings.

Economic Impact

CSDA presumes that due to increased utilization of this dental service, disbursements for such services will increase the expenses to the state for Medicaid dental services. DSS has confirmed that ITR is a covered service regardless of whether it is performed by a dentist or a dental hygienist. CSDA also suggests that the state may ultimately save money due to a potential decrease in emergency room visits that may be avoided if hygienists are allowed to perform ITR which will stabilize patients until they are able to receive more definitive care.

Regional and National Trends

CSDA identified the following regional and national trends in related to dental hygienists and the performance of ITR:

Concepts to increase access to care are being debated around the country. New provider models have been proposed in many states with enactment occurring in multiple locales. However, increased access to care and utilization has not been proven by any of these models as of yet. ITR has proven its efficacy in the US and around the world and has been included in many of the diverse models of care being proposed around the country. Currently 30 states allow hygienists to perform ITR to some degree. ME and OR allow it without supervision whereas the following states have

various limitations to specific ad advanced categories or certification of hygienists and all require the dentist to authorize and be on-site: AL; AZ; AR; CA; FL; IL; KS; KY; MD; MN; MS; MT; NE; NV; NH; NJ; NY; NC; OH; RI; TN; TX; VT; VA; WA; WV; WI and WY.

Other Health Care Professions that may be Impacted by the Scope of Practice Request as Identified by the Requestor

CSDA indicates that the dental hygiene profession will be responsible for implementing the increased scope of practice in treating patients in public health and institutional settings. They also indicate that multiple meetings with key stakeholders, including CSDA, CDHA, CDAA and the Connecticut Health Foundation, regarding increased scope of practice for dental hygienists have been positive but final resolution had not been reached.

<u>Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training</u>

CSDA indicated that once dental hygienists are educated and trained to perform the increased scope, implementation of this scope of practice change should allow an increase in care delivered to the target population. They also indicated that discussions they have had with the University of Connecticut, School of Dental Medicine relative to this educational process have been positive and could be instituted in a short period of time.

Findings and Conclusions

The scope of practice review committee reviewed and evaluated the CSDA's request to expand the dental hygiene scope of practice as well as subsequent written responses to the request and additional information that was gathered through the review process. Literature and other information reviewed and evaluated by the scope of practice review committee demonstrated that Interim Therapeutic Restoration (ITR) with hand instruments is a safe and effective procedure that should be included within the dental hygiene scope of practice, and would be particularly useful in the public health settings where dental hygienists are already treating patients who may benefit from this procedure. Evidence supports that the procedure is successful in slowing the disease process and buys additional time for the patient to get an appointment to see a dentist for more definitive care. It should be noted that practitioners must be careful in educating patients that ITR is not complete treatment and stress the importance of the need for follow-up care with a dentist. In addition, evidence supports the view that in most cases, providing an interim measure such as ITR is far better than simply allowing the decay to continue. ITR would also allow a hygienist to restore and prevent further decalcification and carries in young patients, uncooperative patients or patients with special needs when the placement of traditional dental restorative materials are not feasible. Studies are available that demonstrate that while ITR is not a definitive treatment, it may stabilize the diseased dentition for up to 4 years.

If ITR is added to the scope of dental hygiene practice, the practice act must also be clarified to include references to dental hygiene triage and diagnosis. It would be within the dental hygienist's discretion to triage the patient and determine whether ITR is appropriate at that time or whether an immediate referral to a dentist is required. Education and training related to the performance of ITR can certainly be incorporated into existing accredited dental hygiene education programs moving forward and an interim program could be developed by Connecticut's accredited dental hygiene programs or the dental school to allow currently licensed dental hygienists to gain competency in this procedure.

The scope of practice review committee did not identify any public health and safety risks associated with the request, provided the changes would be implemented in conjunction with the above recommended statutory revisions related to the dental hygiene practice act and educational programs are able to offer the necessary training. Evidence provided by the CSDA demonstrated that enactment of these changes has the potential to enhance quality and affordable health care in Connecticut and enhances the ability of the dental hygiene profession to practice to the full extent of its education and training.

The committee was not presented with draft statutory revisions for review. Should the Public Health Committee decide to raise a bill related to CSDA's scope of practice request, the Department of Public Health along with the pertinent organizations that were represented on the scope of practice review committee to review this request (CSDA and CDHA) respectfully request the opportunity to work with the Public Health Committee on revised statutory language.

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Appendix A



Substitute House Bill No. 6549

Public Act No. 11-209

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S OVERSIGHT RESPONSIBILITIES RELATING TO SCOPE OF PRACTICE DETERMINATIONS FOR HEALTH CARE PROFESSIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2011*) (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

- (b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:
- (A) A plain language description of the request;
- (B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;
- (C) The impact that the request will have on public access to health care;
- (D) A brief summary of state or federal laws that govern the health care profession making the request;
- (E) The state's current regulatory oversight of the health care profession making the request;
- (F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;
- (G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;
- (H) The extent to which the request directly impacts existing relationships within the health care delivery system;

- (I) The anticipated economic impact of the request on the health care delivery system;
- (J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;
- (K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and
- (L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.
- (2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 2 of this act. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.
- (c) In any year in which a scope of practice request is received pursuant to this section, not later than September fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.
- (d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the department a written statement identifying the nature of the impact not later than October first of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October fifteenth of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

- Sec. 2. (NEW) (Effective July 1, 2011) (a) On or before November first of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 1 of this act. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 1 of this act, to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.
- (b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.
- (c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.
- Sec. 3. (NEW) (Effective July 1, 2011) On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 1 and 2 of this act and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes, on the effectiveness of such processes in addressing scope of practice

requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

Approved July 13, 2011

Appendix B

Interim Therapeutic Restorations with Hand Instruments (ITR)

Scope of Practice Committee Members

Jennifer Filippone, Department of Public Health
Wendy Furniss, Department of Public Health
Jennifer Lefkowski, Department of Public Health
Tatiana Barton, Connecticut State Dental Association, President
Dr. John Raus, Connecticut State Dental Association
Carolyn Malon, Connecticut State Dental Association
L. Teal Mercer, RDH, Connecticut Dental Hygienist Association
Dinah G. Auger, Connecticut Dental Hygienist Association
Jody Bishop-Pulla, Connecticut Dental Hygienist Association
Celeste Baranowski, Connecticut Dental Hygienist Association
Marcia H. Lorentzen, RDH, EdD, Connecticut Dental Hygienist Association
Mary Calka, Connecticut Dental Hygienist Association
John Hillger, Connecticut State of Oral Maxillofacial Society
lan Tergary, Connecticut State of Oral Maxillofacial Society

Appendix C



Connecticut State Dental Association

835 West Queen Street Southington, CT 06489

860.378.1800 / phone 860.378.1807 / fax

CSDA.com

August 11, 2011

Jennifer L. Filippone, Chief Practitioner Licensing and Investigations Section Department of Public Health 410 Capitol Avenue, MS#12MQA P.O. Box 340308 Hartford, CT 06134

Dear Jennifer,

Per Public Act 11-209, An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations For Health Care Professions, we are submitting a scope request which would increase the scope of practice for dental hygienists in public health and institutional settings to include Interim Therapeutic Restorations with hand instruments.

In an attempt to foster collaboration and broad agreement to this proposal the CSDA has reached out to various appropriate stakeholder groups to include the CT Health Foundation, CT Oral Health Collaborative, the PEW Foundation, the CT Dental Assistant Association, and the CT Dental Hygiene Association (CDHA). All of these organizations, with the exception of the CDHA, support this increase in scope as a means to have an immediate effect on populations with little access to traditional dental care. Because of CDHA's objection, we are regrettably unable to request that an exemption from the process be granted.

In closing, the CSDA looks forward to working with the Department and all interested partners through this new scope process in the hopes of identifying real solutions that will positively impact the lives of the citizens of Connecticut. Please do not hesitate to contact me should you have any additional questions.

Sincerely,

Tatiana Barton, DDS

President



Connecticut State Dental Association

835 West Queen Street Southington, CT 06489

860.378.1800 / phone 860.378.1807 / fax

CSDA.com

Scope Request- Interim Therapeutic Restorations (ITR)

A plain language description of the request:

This request is for increasing the scope of practice for dental hygienists in public health and institutional settings to include ITR with hand instruments.

Alternative/atraumatic restorative technique (ART) has been endorsed by the World Health Organization as a means of restoring and preventing caries in populations with little access to traditional dental care. Interim therapeutic restoration (ITR) more accurately describes the procedure used in contemporary dental practice in the US. ITR utilizes similar techniques as ART but has different therapeutic goals. ITR may be used to restore and prevent further decalcification and caries in young patients, uncooperative patients, or patients with special health care needs, and when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed. Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth. The use of ITR has been shown to reduce the levels of carcinogenic oral bacteria in the oral cavity. The procedure involves removal of caries using hand instruments by hygienists with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as self-setting or resin-modified glass ionomer. ITR has the greatest success when applied to single surface or small 2 surface restorations. Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations.

Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented:

As seen in Connecticut, increasing the capacity of the dental delivery system with 1300 dentists treating the Medicaid population does not increase utilization of dental services to the level of the population with the financial means to seek care. This is due to socioeconomic issues such as the ability of the parents of children to take time from work, arrange transportation, or valuing such services. In school based programs, these children do have access to care, mostly by hygienists, who see lesions that could be treated by this therapy. This has been noted during discussions with the Connecticut Dental Hygiene Association (CDHA). Due to the short and cost effective training period to teach this competency, it can have an immediate effect on the target population as the

debate on other scope of practice issues continues across the country. Failure to implement such a change will continue the present status of care in schools and institutions across Connecticut.

The impact that the request will have on public access to health care: (see above)

A brief summary of state or federal laws that govern the health care profession making the request:

Chapter 379 of the CT General Statutes governs the profession of dentistry. Chapter 379a of the General Statutes governs Dental Hygienists.

The state's current regulatory oversight of the health care profession making the request: Chapter 379 of the CT General Statutes governs the profession of dentistry. Chapter 379a of the General Statutes governs Dental Hygienists.

All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request: Chapter 379 of the CT General Statutes governs the profession of dentistry. Chapter 379a of the General Statutes governs Dental Hygienists.

A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of this request:

Multiple bills have been put forward to increase the scope of practice for dental hygienists to include competencies presently employed by dentists with far greater training.

The extent to which the request directly impacts existing relationships within the health care delivery system:

The request increases the scope of practice for dental hygiene to address the determined needs of the target population. This collaborative effort by organized dentistry and dental hygiene may improve the relationship between the organizations.

The anticipated economic impact of the request on the health care delivery system:

Due to increased utilization of this dental service, disbursements for such services will increase the expenses to the state for Medicaid dental services.

Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states:

Concepts to increase access to care are being debated around the country. New provider models have been proposed in many states with enactment occurring in multiple locales. However, increased access to care and utilization has not been proven by any of these models as of yet. Until data proves a particular model

effective, Connecticut should only move forward with competencies of care that have a proven track record These models change as stakeholders look for positive answers yet have consistently maintained ITR as a competency. ITR has proven its efficacy in the US and around the world and has also been included in many of the diverse models of care being proposed around the country. Currently 30 states allow hygienists to perform ITR to some degree. ME and OR allow it without supervision .Oregon also permits without on-site supervision under the Limited Access Permit program, with a docs agreement. Once new rules are adopted the newly enacted Expanded Function Dental Hygienist will be able to do this off-site, within a collaborative agreement, if approved within the standing orders of the collaborating dentist. This is authorized within the enactment of SB 738. The following states have various limitations to specific advanced categories or certification of hygienists and all require the dentist to authorize and to be on-site: AL; AZ; AR; CA; FL; IL; KS; KY; MD; MN; MS; MT; NE; NV; NH; NJ; NY; NC; OH; RI; TN; TX; VT; VA; WA; WV; WI; and WY.

Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions:

The dental hygiene profession will be responsible for implementing the increased scope of practice in treating patients in public health and institutional settings. It will answer some of their concerns for oral health issues seen in their clinic settings. Multiple meetings have been held with the CDHA, CDAA (Connecticut Dental Assistant Association, and CHF (Connecticut health Foundation) regarding this increase in scope of practice. These meeting have been positive but as of yet, the CDHA has not signed off on the increase, even though it is a competency they have requested as part of their increase of scope request for the Advanced Dental Hygiene Practioner (ADHP) model.

A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training:

This increase in scope will require further education for the dental hygiene profession. Once completed, this should allow an increase in care delivered to the target population. Discussions with UCSDM relative to this educational process have been positive and could be instituted in a short period of time.

Appendix D

The Kowalski Group, L.L.C.

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September 30, 2011

<u>MEMORANDUM</u>

TO: Jennifer L. Filippone

Department of Public Health

FR: Linda A. Kowalski

The Kowalski Group, LLC

I am writing on behalf of the Connecticut Dental Hygienists Association, a professional organization of licensed Dental Hygienists in the state. I would like to submit this impact statement in response to the Connecticut State Dental Association's proposal to permit dental hygienists to perform Interim Therapeutic Restorations with hand instruments in certain settings. CDHA has commented on the specific impact of the proposal in the attached impact statement.

CDHA has a strong interest in it since it relates to duties performed by Dental Hygienists. This issue is ripe for discussion and resolution by a scope of practice review committee. To this end, CDHA commits to fully participate in the work of such committee if it is created by DPH, and will designate two members of our organization to participate.

Please let me know if you have any questions about this matter. I can be reached at (860) 246-4346 or lkowalski@thekowalskigroup.com by email.

Thank you.

Attachment-CDHA impact statement





ORIGIN OF DENTAL HYGIENE 1913

CONNECTICUT **D**ENTAL **H**YGIENISTS' **A**SSOCIATION, INC. ADVOCATES FOR ORAL HEALTH MANAGEMENT

Impact Statement Response to the Department of Public Health (DPH)
Jennifer L. Filippone, Chief -- Hartford, CT
Practioner Licensing and Investigation Section
Connecticut Department of Public Health

September 30, 2011

Regarding Request: submitted August 15, 2011 by the Connecticut State Dental Association (CSDA) for a Scope of Practice Change to allow education and training for licenced, registered dental hygienists in public health and institutional settings to perform **Interim Therapeutic Restorations** (ITR) with hand instruments. The request was submitted per Public Act 11-209 AAC the Department of Public Health's Oversite Responsibilities Relating to Scope of **Practice Determinations** for Health Care Professions.

The Connecticut Dental Hygienists' Association (CDHA) is in the process of reviewing this proposal

Framework:

- The Connecticut Dental Hygienists' Association (CDHA) supports the safety of the public
- CDHA supports a collaborative working relationship with all dental team members
- CSDA, CDHA and CDAA members were represented on the original ADHOC committee
 - o CDHA participated in discussions of the seven items charged to us by former Comissioner Galvin
 - Legislation as defined in House Bill 5636 passed as Special Act No. 04-7 in 2004
 - Five items passed two concerning specific workforce models did not pass they were:
 - EFDA (Expanded Function Dental Auxiliary) &
 - ADHP (Advanced Dental Hygiene Practitioner)
 - o In good faith, CDHA has participated in many discussions regarding EFDA since 2004
 - CDHA has invited CSDA & CDAA to participate in discussions regarding mid-level dental hygiene providers -- CSDA & CDAA have both attended meetings
 - CDAA has participated in subsequent discussions and offered input
 - CSDA has regrettablly has not given cogent input regarding mid-level dental hygiene providers
- CDHA has always participated in discussions

When CSDA reached out to various stakeholder groups - as alluded to in their cover letter — CDHA requested a description of how they anticipated the ITR proposal would present - although requested this is the first and only draft proposal received by CDHA. The CDHA Board will put this on their agenda so it can be discussed.





ORIGIN OF DENTAL HYGIENE 1913

CONNECTICUT **D**ENTAL **H**YGIENISTS' **A**SSOCIATION, INC. ADVOCATES FOR ORAL HEALTH MANAGEMENT

CDHA advocates that any proposal to expand the present status of oral health care in schools and institutions, by licensed, registered dental hygienists should include at the onset the addition of:

- Dental Hygiene Diagnosis
- Dental Hygiene Triage
- Laser Certification and other emerging technologies certification(s)
- Utilization of all evidence based treatment modalities or devices to provide oral health services.

CDHA does not see the ITR proposal as a solution to improving access, but as another bandaid application, when looked at with the more comprehensive approach of an (Advanced Dental Hygiene Practitioner) ADHP.

In accordance with the current laws protecting the health of the public CDHA requests clarification on

- the proposed educational curriculum
 - o what it will entail clinical experience and scientific foundation
 - o where will it take place
- the economic impact to the state, the consumer and the profession
 - will it be folded into the current dental hygiene curriculum
- the health benefits to the public
 - this treatment may lead to the perception that ITR treatment is complete treatment and that follow-up care is not indicated - patients may not return for the indicated follow-up care
 - is there evidence based research that the benefit outweighs the concerns
- the increase to access to care
 - while we acknowledge the merits of ART & ITR the proposal does not increase access on its own
 - The ADHP (Advanced Dental Hygiene Practitioner) comprehensive solution would increase access
- whether this proposal meets the unmet needs of our states constituents
- dental supervision as Public Health settings often do not employ dentists

The proposal affects the most vulnerable Connecticut citizens and therefore must be thoughly scrutinized.

VIA E-MAIL: jennifer.filippone@ct.gov

Jennifer L. Filippone Chief Practitioner Licensing and Investigations Section Department of Public Health 410 Capitol Avenue, MS#12MQA PO Box 340308 Hartford, CT 06134

Dear Ms. Filippone:

I am submitting this response on behalf of the 92 members of the Connecticut Association of Endodontists (CAE). This impact statement is submitted under the provisions of Public Act 11-209 in response to the "Scope of Practice Request" submitted by the Connecticut State Dental Association (CSDA). The CAE supports the concept of appropriately trained dental auxiliaries placing Interim Therapeutic Restorations (ITR).

The concept of ITR is to get basic, temporary care available where it is easy to provide. Decay is a progressive disease that gets worse with time. A simple cavity gets bigger and will eventually cause the need for endodontic therapy (Root Canal). If not caught at this point it could cause the loss of a tooth. This proposal would allow appropriately trained auxiliaries to use hand instruments to remove the most obvious amounts of decay and then seal the cavity with a temporary filling. This process would slow the disease process and buy some time for the patient to get an appointment to see a dentist for more definitive care. Despite the numbers we receive from the Department of Social Services showing that the citizens of our state do not have to wait unreasonable amounts of time for dental appointments, there are still citizens who do not seek care in a regular or timely manner. A dental auxiliary providing screenings in a school environment might discover unmet needs that could then be addressed both in stabilizing the dental need and educating the patient and parent if appropriate to get the needs addressed.

This request is a minor increase in the scope of practice for a dental hygienist. Because it involves the removal of decay via hand instruments there is next to no risk to the patient.

On behalf of the CAE I wish to again state our support of the ITR proposal. Thank you for your consideration. Please contact me if you have any questions or would like additional information.

Sincerely,

Brian Amoroso, DDS President Connecticut Association of Endodontists



Connecticut State Dental Association

835 West Queen Street Southington, CT 06489

860.378.1800/phone 860.378.1807/fax

CSDA.com

October 14, 2011

Jennifer L. Filippone
Chief, Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12MQA
P.O. Box 340308
Hartford, CT 06134
Jennifer.filippone@ct.gov

Dear Ms. Filippone,

Per Public Act 11-209, An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations For Health Care Professions, the Connecticut State Dental Association (CSDA) as you know has submitted a "Scope Request" that would allow a Connecticut licensed dental hygienist to perform Interim Therapeutic Restorations (ITR). The Connecticut Association of Endodontists (CAE) subsequently submitted an "Impact Statement" in support of the ITR Scope Request. The below letter was today forwarded to the CAE and constitutes our Response to their Impact Statement.

On behalf of the dental team I thank-you for your supporting impact statement on the recent scope of practice request which would allow hygienists to perform ITR. We note the agreement you have with our request, the lack of any disagreement, and thank-you for your support.

Sincerely,

Tatiana Barton, DMD

President



Connecticut State Dental Association

835 West Queen Street Southington, CT 06489

860.378.1800/phone 860.378.1807/fax

CSDA.com

October 14, 2011

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Dear Ms. Filippone,

Per Public Act 11-209, An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations For Health Care Professions, the Connecticut State Dental Association (CSDA) has submitted a "Scope Request" that would allow a Connecticut licensed dental hygienist to perform Interim Therapeutic Restorations (ITR). The Connecticut Dental Hygiene Association (CDHA) subsequently submitted an "Impact Statement" with regards to the ITR Scope Request. The below letter was today forwarded to the CDHA and constitutes our Response to their Impact Statement.

After reviewing your Impact Statement we were able to identify some areas of agreement, as well as areas of disagreement:

Areas of Agreement

- "[ITR] for hygienists is ripe for discussion and resolution by a scope of practice review committee."
- "Both the CSDA and the CDHA support a collaborative working relationship with all dental team members."

Areas of Disagreement

• "CSDA has regrettably not given cogent input regarding mid-level dental hygiene practitioners." Throughout the Impact Statement regarding ITR for hygienists, there are numerous references to the Advanced Dental Hygiene Practitioner and Expanded Function Dental Auxiliaries (EFDA). While possible points of discussion through the scope of practice review process, they are not relevant as an Impact Statement on a Scope Request regarding ITR for hygienists. Furthermore, we respectfully suggest that all comments and/or questions

regarding EFDA be directed to the Connecticut Dental Assistant Association, the source of the EFDA request.

• "CDHA does not see the ITR proposal as a solution to improving access, but as another band-aid application." As we know, there is no single solution to increasing access to oral health care for those in Connecticut. Even when there is ample capacity in the system as presently seen with 1,300 participating dentists in the Connecticut Dental Health Partnership and with data supplied by the Department of Social Services supporting this fact, we cannot force the target population to utilize the available care. Allowing hygienists to perform ITR would be another tool that the existing dental team could utilize in order help those who choose to access dental care. As we debate other strategies for improving oral health, ITR can be easily and quickly implemented without long drawn out pilots and educational programs. We see this as a way to help the target population now, not 5 or 10 years in the future.

Responses to some of your additional questions:

• The proposed educational curriculum. What will it entail and where will it take place?

Teaching of this modality has been discussed with the University of Connecticut, School of Dental Medicine. Presently taught to dental students before charitable trips to foreign countries, a curriculum could quickly be developed to train dental hygienists who desire the extra training. Other potential venues could be the dental hygiene schools of Connecticut. Due to its acceptance and use around the world, a curriculum would not necessarily need to be reinvented, but modified to be applicable in Connecticut.

- What is the economic impact to the state? With numerous CT hygienists working independently in the public health setting where they are allowed to bill directly, legislative change would allow the hygienist to perform ITR until the patient was able to receive more definitive care. This will ultimately save the state money due to a decrease in potential emergency room costs.
- What are the health benefits to the public? ITR would allow a hygienist to restore and prevent further decalcification and caries in young patients, uncooperative patients or patients with special needs when the placement of traditional dental restorative materials are not feasible. Studies are available that show, while not definitive treatment, that ITR may stabilize the diseased dentition for up to 4 years.

The CSDA is heartened by your interest in our proposal to allow hygienists to perform ITR and look forward to working with you throughout the scope of practice process should the Department choose to move forward with this proposal.

Sincerely,

Tatiana Barton, DMD

President

Appendix E

CHAPTER 379a DENTAL HYGIENISTS

<u>Sec. 20-126h. License.</u> No person shall engage in the practice of dental hygiene unless he has obtained a dental or dental hygiene license issued by the department of public health.

- Sec. 20-126i. Application for license. (a) Each application for a license to practice dental hygiene shall be in writing and signed by the applicant and accompanied by satisfactory proof that such person has received a diploma or certificate of graduation from a dental hygiene program with a minimum of two academic years of curriculum provided in a college or institution of higher education the program of which is accredited by the Commission on Dental Accreditation or such other national professional accrediting body as may be recognized by the United States Department of Education, and a fee of one hundred fifty dollars.
- (b) Notwithstanding the provisions of subsection (a) of this section, each application for a license to practice dental hygiene from an applicant who holds a diploma from a foreign dental school shall be in writing and signed by the applicant and accompanied by satisfactory proof that such person has (1) graduated from a dental school located outside the United States and received the degree of doctor of dental medicine or surgery, or its equivalent; (2) passed the written and practical examinations required in section 20-126j; and (3) enrolled in a dental hygiene program in this state that is accredited by the Commission on Dental Accreditation or its successor organization and successfully completed not less than one year of clinical training in a community health center affiliated with and under the supervision of such dental hygiene program.
- **Sec. 20-126j.** Examination of applicants. Except as provided in section 20-126k, each applicant for a license to practice dental hygiene shall be examined through written and practical examinations by the department of public health, as to his professional knowledge and skill before such license is granted. All examinations shall be given at least once per year and at other times prescribed by the department. Such examination shall be conducted in the English language. The commissioner of public health may accept and approve, in lieu of the written examination required in this section, the results of a written examination given by the Joint Commission on National Dental Examinations or comparable national examinations subject to such conditions as said commissioner may prescribe; and said commissioner may accept and approve, in lieu of the practical examination required in this section, the results of practical examinations given by regional testing agencies subject to such conditions as the department of public health may prescribe. Passing scores shall be prescribed by the department of public health. Said department shall grant licenses to such applicants as are qualified.
- Sec. 20-126k. Licensure without examination. The department of public health may, without examination, issue a license to any dental hygienist who has provided evidence of professional education not less than that required in this state and who is licensed in some other state or territory, if such other state or territory has requirements of admission determined by the department to be similar to or higher than the requirements of this state, upon certification from the board of examiners or like board of the state or territory in which such dental hygienist was a practitioner certifying to his competency and upon payment of a fee of one hundred fifty dollars to said department. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Sec. 20-126l. Definitions. Scope of practice. Limitations. Continuing education.

- (a) As used in this section:
- (1) "General supervision of a licensed dentist" means supervision that authorizes dental hygiene procedures to be performed with the knowledge of said licensed dentist, whether or not the dentist is on the premises when such procedures are being performed;
- (2) "Public health facility" means an institution, as defined in section 19a-490, a community health center, a group home or a school, a school, a preschool operated by a local or regional board of education or a head start program; and

- (a) The "practice of dental hygiene" means the performance of educational, preventive and therapeutic services including: Complete prophylaxis; the removal of calcerous deposits, accretions and stains from the supragingival and subgingival surfaces of the teeth by scaling, root planing and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth; dental hygiene examinations and the charting of oral conditions; dental hygiene assessment, treatment planning and evaluation; the administration of local anesthesia in accordance with the provisions of subsection (d) of this section; and collaboration in the implementation of the oral health care regimen.
- (b) No person shall engage in the practice of dental hygiene unless such person (1) has a dental hygiene license issued by the Department of Public Health and (A) is practicing under the general supervision of a licensed dentist, or (B) has been practicing as licensed dental hygienist for at least two years, is practicing in a public health facility and complies with the requirements of subsection (e) of this section, or (2) has a dental license.
- (c) A dental hygienist licensed under sections 20-126h to 20-126w, inclusive, shall be known as a "dental hygienist" and no other person shall assume such title or use the abbreviation "R.D.H." or any other words, letters or figures which indicate that the person using such words, letters or figures is a licensed dental hygienist. Any person who employs or permits any other person except a licensed dental hygienist to practice dental hygiene shall be subject to the penalties provided in section 20-126t.
- (d) A licensed dental hygienist may administer local anesthesia, limited to infiltration and mandibular blocks, under the indirect supervision of a licensed dentist, provided the dental hygienist can demonstrate successful completion of a course of instruction containing basic and current concepts of local anesthesia and pain control in a program accredited by the Commission on Dental Accreditation, or its successor organization, that includes: (1) Twenty hours of didactic training, including, but not limited to, the psychology of pain management; a review of anatomy, physiology, pharmacology of anesthetic agents, emergency precautions and management, and client management; instruction on the safe and effective administration of anesthetic agents; and (2) eight hours of clinical training which includes the direct observation of the performance of procedures. For purposes of this subsection, "indirect supervision" means a licensed dentist authorizes and prescribes the use of local anesthesia for a patient and remains in the dental office or other location where the services are being performed by the dental hygienist.
- (e) A licensed dental hygienist shall in no event perform the following dental services: (1) Diagnosis for dental procedures or dental treatment; (2) the cutting or removal of any hard or soft tissue or suturing; (3) the prescribing of drugs or medication which require the written or oral order of a licensed dentist or physician; (4) the administration of parenteral, inhalation or general anesthetic agents in connection with any dental operative procedure; (5) the taking of any impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis; (6) the placing, finishing and adjustment of temporary or final restorations, capping materials and cement bases.
- (f) Each dental hygienist practicing in a public health facility shall (1) refer for treatment any patient with needs outside the dental hygienist's scope of practice, and (2) coordinate such referral for treatment to dentists licensed pursuant to chapter 379.
- (g) All licensed dental hygienists applying for license renewal shall be required to participate in continuing education programs. The commissioner shall adopt regulations in accordance with the provisions of chapter 54 to: (1) Define basic requirements for continuing education programs, (2) delineate qualifying programs, (3) establish a system of control and reporting, and (4) provide for waiver of the continuing education requirement by the commissioner for good cause.
- **Sec. 20-126m. Display of license.** The license for the current year shall be displayed conspicuously in the office, place of business or place of employment of each licensee. Each licensed dental hygienist shall forthwith notify the department of any change of address or employment subsequent to his licensure.
- <u>Sec. 20-126n. License renewal.</u> Licenses issued under sections 20-126h to 20-126w, inclusive, shall be renewed annually in accordance with the provisions of section 19a-88.

- Sec. 20-1260. Disciplinary action by the department. (a) The department of public health may take any of the actions set forth in section 19a-17 of the 2008 supplement to the general statutes for any of the following causes: (1) The presentation to the department of any diploma, license or certificate illegally or fraudulently obtained, or obtained from an institution that is not accredited or from an unrecognized or irregular institution or state board, or obtained by the practice of any fraud or deception; (2) illegal conduct; (3) negligent, incompetent or wrongful conduct in professional activities; (4) conviction of the violation of any of the provisions of sections 20-126h to 20-126w, inclusive, by any court of criminal jurisdiction; (5) the violation of any of the provisions of said sections or of the regulations adopted hereunder or the refusal to comply with any of said provisions or regulations; (6) the aiding or abetting in the practice of dental hygiene of a person not licensed to practice dental hygiene in this state; (7) engaging in fraud or material deception in the course of professional activities; (8) the effects of physical or mental illness, emotional disorder or loss of motor skill, including but not limited to, deterioration through the aging process, upon the license holder; (9) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; or failure to provide information to the Department of Public Health required to complete a health care provider profile, as se forth in section 20-13, as amended by public act 08-109. A violation of any of the provisions of sections 20-126h to 20-126w, inclusive, by any unlicensed employee in the practice of dental hygiene, with the knowledge of his employer, shall be deemed a violation thereof by his employer. The commissioner of public health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to said section 19a-17 of the 2008 supplement to the general statutes.
- (b) For purposes of subdivision (7) of subsection (a) of this section, fraud or material deception shall include, but not be limited to, the following practices: (1) Submission of a claim form to a third party intentionally reporting incorrect treatment dates for the purpose of assisting a patient in obtaining benefits under a dental plan, which benefits would otherwise be disallowed; (2) increasing a fee to a patient for a service in excess of the fee charged solely because the patient has dental insurance; (3) intentionally describing a dental hygiene procedure incorrectly on a third-party claim form in order to receive a greater payment or reimbursement or intentionally misrepresenting a dental hygiene procedure not otherwise eligible for payment or reimbursement on such claim form for the purpose of receiving payment or reimbursement; and (4) intentionally accepting payment from a third party as payment in full for patient services rendered when (A) the patient has been excused from payment of any applicable deductible by the license holder and (B) such license holder fails to notify the third party of such action.
- **Sec. 20-126p.** Change of residence out of state. Any licensed dental hygienist changing his residence or place of business to another state shall, upon application to the department of public health, receive a certificate which shall state that he is a licensed dental hygienist and such certificate shall be given without payment of any fee.
- **Sec. 20-126q.** False representations. No person shall falsely claim to hold a certificate of registration, license, diploma or degree granted by a society, school or by the department of public health, or, with intent to deceive the public, pretend to be a graduate of any dental hygiene program or college, or append the letters "R.D.H." to his name, without having the degree indicated by such letters conferred upon him by diploma from a college, a school, a board of examiners, or other agency empowered to confer the same.
- **Sec. 20-126r.** Appeal. Any licensee aggrieved by the action of the department of public health in suspending or revoking any license under the provisions of sections 20-126h to 20-126w, inclusive, may appeal therefrom as provided in section 4-183. Appeals brought under this section shall be privileged with respect to the order of trial assignment.
- <u>Sec. 20-126s. Payment for dental hygiene care of patients in chronic and convalescent hospitals and convalescent homes.</u> Payment for dental hygiene care rendered to patients in chronic and convalescent hospitals or convalescent homes shall be made directly to the dental hygienist rendering such care. The commissioner of social services shall not be required to recognize the cost of employing or

contracting with a dental hygienist in the rates established for convalescent homes pursuant to section 17b-340.

Sec. 20-126t. Penalties. Any person who violates any provision of sections 20-126h to 20-126w, inclusive, shall be fined not more than five hundred dollars or imprisoned not more than five years or both. Any person who continues to practice dental hygiene or engage as a dental hygienist, after his license or authority to so do has been suspended or revoked and while such disability continues, shall be fined not more than five hundred dollars or imprisoned not more than five years or both. For purposes of this section each instance of patient contact or consultation which is in violation of any provision of this section shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

Sec. 20-126u. Regulations. The commissioner of public health may adopt regulations, in accordance with chapter 54, to implement the provisions of sections 20-126h to 20-126w, inclusive.

Sec. 20-126w. Construction of chapter. Nothing in sections 20-126h to 20-126v, inclusive, shall be construed to (1) allow a dental hygienist to practice beyond the parameters of the general supervision of a licensed dentist, as defined in section 20-1261, as amended by this act, or (2) prevent a licensed dentist from providing dental hygiene services.

Sec. 20-126x. Professional liability insurance required, when. Amount of insurance. Reporting requirements. (a) Each person licensed to practice dental hygiene under the provisions of this chapter who provides direct patient care services shall maintain professional liability insurance or other indemnity against liability for professional malpractice. The amount of insurance that each such person shall carry as insurance or indemnity against claims for injury or death for professional malpractice shall not be less than five hundred thousand dollars for one person, per occurrence, with an aggregate of not less than one million five hundred thousand dollars.

(b) Each insurance company that issues professional liability insurance, as defined in subdivisions (1), (6), (7), (8) and (9) of subsection (b) of section 38a-393 of the general statutes, shall, on and after January 1, 1997, render to the Commissioner of Public health a true record of the names, according to classification, of cancellations of and refusals to renew professional liability insurance policies and the reasons for such cancellations or refusal to renew said policies for the year ending on the thirty-first day of December next preceding.

Regulations of Connecticut State Agencies Continuing Education Requirements for Annual License Renewal by Dental Hygienists

Sec. 20-111-1. Definitions

For the purpose of these regulations, the following definitions apply.

- (a) "Department" means the Department of Health Services.
- (b) "Licensee" means a dental hygienist licensed pursuant to Connecticut General Statutes, Section 20-111.
- (c) "License renewal due date" means the last day of the month of the licensee's birth.
- (d) "Registration period" means the one-year period during which a license which has been renewed in accordance with Connecticut General Statutes, Section 19a-88, is current and valid and which one year period terminates on the license renewal due date.
- (e) "Continuing education monitoring period" means a period beginning in an odd-numbered year and consisting of two consecutive registration periods.
- (f) "Active practice" means the treatment in Connecticut of one or more patients by a licensee during any given registration period.
- (g) "Provider" means the individual, organization, educational institution or other entity conducting the continuing education activity. Providers include but are not limited to: educational institutions accredited by the American Dental Association; the American Dental Association and its component organizations; the National Dental Association and its component organizations; the American Dental Hygienists Association and its component organizations; the National Dental Hygienists Association and its component organizations; the Academy of General Dentistry and its component organizations; the American Red Cross and the American Heart Association when sponsoring programs in cardiopulmonary resuscitation or cardiac life support; and the Veterans Administration and Armed Forces when conducting programs at United States governmental facilities.
- (h) "Participant" means a licensee who completes a continuing education activity.
- (i) "Contact hour" means a minimum of 50 minutes of continuing education activity.
- (j) "Face-to-face instruction" means direct, live instruction which a participant physically attends, either individually or as part of a group of participants.
- (k) "Certificate of completion" means a document issued to a participant by a provider which certifies that said participant has successfully completed a continuing education activity. Such certificate shall include: participant's name; provider's name; title or subject area of the activity; date(s) and location of attendance; and number of contact hours completed.

Sec. 20-111-2. Number of credits required

- (a) Each licensee shall complete a minimum of 16 credit hours of continuing education during each continuing education monitoring period.
- (b) A licensee shall not carry over continuing education credit hours to a subsequent continuing education monitoring period.

Sec. 20-111-3. Criteria for continuing education

Continuing education activities will satisfy the requirements of these regulations, provided:

- 1) the activity involves face-to-face instruction;
- 2) the provider implements a mechanism to monitor and document physical attendance at such face-to-face instruction;
- the provider retains written records for a period of three years including but not limited to: content description; instructor; date(s) of course; location of course; list of participants; and number of contact hours;
- 4) the provider implements a mechanism to evaluate participants' attainment of educational objectives and participants' assessment of the educational activity;
- 5) the provider issues a certificate of completion; such certificate may not be issued by the provider prior to the licensee's actual completion of the activity;
- 6) the activity focuses on content specified in Section 4 of these regulations.

Sec. 20-111-4. Content areas for continuing education

Subject matter for continuing education will reflect the professional needs of the licensee in order to meet the health care needs of the public. Accordingly, only those continuing education activities which provide significant theoretical or practical content directly related to clinical or scientific aspects of dental hygiene will meet the requirements of these regulations. Activities consisting of the following subject matter will not qualify as continuing education activities: organization and design of a dental office, practice development, marketing, investments or financial management, personnel management, or personal health, growth or development when content is designed for personal use as opposed to patient care or patient instruction.

Sec. 20-111-5. Award of credit hours

- (a) Continuing education credit hours will be awarded as follows:
 - (1) courses, institutes, seminars, programs, clinics, and scientific meetings: 1 credit hour for each contact hour of attendance.
 - (2) Multiday convention-type meetings at the state, regional, or national level: 2 credit hours for attendance.
 - (3) Full-time post-graduate enrollment in an advanced educational program accredited by the American Dental Association: 16 credit hours in continuing education monitoring period in which enrolled.
 - (4) Successful completion of the National Board Dental Hygiene Examination or the North East Regional Board of Dental Examiners Examination in Dental Hygiene, if taken five years or more after graduation from an educational institution teaching dental hygiene which is approved by the dental commission with the consent of the commissioner; 16 credit hours in continuing education monitoring period in which completed.
 - (5) Original presentation by licensee of a paper, essay, or formal lecture in dental hygiene to a recognized group of fellow professionals at a scientific meeting: 3 credit hours for the first presentation only.
 - (6) Original scientific paper published by licensee in a scientific professional journal which accepts papers only on the basis of independent review by experts: 6 credit hours for the first publication only.
 - (7) Original presentation of scientific, educational, or clinical exhibit at a professional meeting: 2 credit hours.
- (b) Eight credit hours will be the maximum continuing education credits granted for any one day's participation in the activities specified in Subsection (a), above.
- (c) The licensee shall successfully complete a continuing education activity for award of any continuing education credit.
- (d) Activities which will not qualify for award of credit hours include professional organizational business meetings; speeches delivered at luncheons or banquets; reading of books, articles, or professional journals; home study courses, correspondence courses, audio-visual materials, and other mechanisms of self-instruction.

Sec. 20-111-6. Record retention by licensees

- (a) Each licensee shall obtain a certificate of completion, for those activities properly completed, from the provider of continuing education activities. Each licensee shall maintain, for continued competency activities specified in Subsection (a) (3) through (a) (7) of Section 5 of these regulations, written documentation of completion. The licensee shall retain certificates of completion and other required documentation for a minimum of two years after the end of the continuing education monitoring period during which the licensee completed the activity.
- (b) The Department shall audit such licensee records as it deems necessary. The licensee shall submit certificates of completion and other required documentation to the Department only upon the Department's request. The licensee shall submit such records to the Department within 45 days of the Department's request for an audit. It will not be necessary for the licensee to submit such documentation in order to renew the license.
- (c) A licensee who fails to comply with the continuing education requirements of these regulations may be subject to disciplinary action, pursuant to Connecticut General Statutes, Section 20-114.

Sec. 20-111-7. Exemption from continuing education requirements

(a) A licensee who is not engaged in active practice during a given continuing education monitoring period shall be exempt from continuing education requirements on submission of a notarized application on a form provided by the Department. The application must contain the statement that the licensee shall

not engage in active practice until the licensee has shown proof of completion of requirements specified in Section 20-111-8 of these regulations.

(b) A licensee applying for license renewal for the first time shall be exempt from continuing education requirements.

Sec. 20-111-8. Requirements for return to active practice following exemption from continuing education requirements

A licensee who has been exempt, pursuant to Subsection (a) of Section 20-111-7 of these regulations, shall submit the following documents upon return to active practice:

- (a) a notarized application on a form provided by the Department; and
- (b) evidence, acceptable to the Department, of:
 - 1) practice of dental hygiene in another state or territory of the United States, or the District of Columbia, for at least one year immediately preceding the application; or
 - 2) successful completion of the National Board Dental Hygiene Examination or the North East Regional Board of Dental Examiners Examination in Dental Hygiene during the year immediately preceding the application; or
 - 3) completion of 8 credit hours of continuing education within six months after returning to active practice, to be applied to the continuing education monitoring period during which the licensee was exempt from such continuing education requirements.

Sec. 20-111-9. Reinstatement of lapsed licenses

Any licensee whose license has become void and who applies to the Department for reinstatement may apply for licensure under the terms of Sections 19a-14-1 to 19a-14-5, inclusive, of the Regulations of Connecticut State Agencies.

Sec. 20-111-10. Effective date of continuing education requirements

These requirements will be effective for registration periods commencing on and after January 1, 1989.

Appendix F



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Bridgeport, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Bridgeport, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider network of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Hartford area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL	23,956	26,717	120,297

Within a ten mile radius from the center of Hartford (greater Hartford area or Hartford region), the CTDHP dental network of providers is as follows:

Provider Type	Total #	Accepting New Clients
General		
Dentist	115	108
Pediatric		
Dentist	9	9
Specialists	31	31
Clinics	9	9
Dental		
Practices	68	62

For the above offices the average wait time for obtaining a routine appointment is approximately 14.1 days.

¹ Network measurement as of December 31, 2010 . The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Danbury, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Danbury, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider net- work of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B, and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Danbury area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			17,312

Within a ten mile radius from the center of Danbury the CTDHP dental network of providers is as follows:

Provider		
Туре	Total #	Accepting New Clients
General		
Dentist	40	37
Pediatric		
Dentist	2	2
Specialists	14	14
Clinics	0	0
Dental		
Practices	30	29

For the above offices the average wait time for obtaining a routine appointment is approximately 10 days.

¹ Network measurement as of December 31, 2010 . The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Enfield, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Enfield, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider net work of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Enfield area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			15,907

Within a ten mile radius from the center of Enfield the CTDHP dental network of providers is as follows:

Provider		
Туре	Total #	Accepting New Clients
General		
Dentist	49	49
Pediatric		
Dentist	4	4
Specialists	31	31
Clinics	0	0
Dental		
Practices	29	29

For the above offices the average wait time for obtaining a routine appointment is approximately 8 days.

¹ Network measurement as of December 31, 2010. The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Hartford, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Hartford, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider network of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Hartford area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL	63,704	56,593	120,297

Within a ten mile radius from the center of Hartford (greater Hartford area or Hartford region), the CTDHP dental network of providers is as follows:

Provider Type	Total #	Accepting New Clients
General		1 9
Dentist	306	218
Pediatric		
Dentist	19	17
Specialists	52	43
Clinics	2	2
Dental		
Practices	141	125

For the above offices the average wait time for obtaining a routine appointment is approximately 14.1 days.

¹ Network measurement as of December 31, 2010. The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Manchester, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Manchester, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider net- work of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Manchester area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			132,110

Within a ten mile radius from the center of Manchester the CTDHP dental network of providers is as follows:

Provider Type	Total #	Accepting New Clients
General		
Dentist	208	185
Pediatric		
Dentist	55	55
Specialists	287	287
Clinics	2	2
Dental		
Practices	103	90

For the above offices the average wait time for obtaining a routine appointment is approximately 13 days.

¹ Network measurement as of December 31, 2010. The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Middletown, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Middletown, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider net- work of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Middletown area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			67,490

Within a ten mile radius from the center of Middletown the CTDHP dental network of providers is as follows:

Provider Type	Total #	Accepting New Clients
General		
Dentist	107	97
Pediatric		
Dentist	39	36
Spe cialists	75	75
Clinics	2	2
Dental		
Practices	56	50

For the above offices the average wait time for obtaining a routine appointment is approximately 12 days.

¹ Network measurement as of December 31, 2010 . The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! New Haven, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in New Haven, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider network of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater New Haven area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL	45,803	43,661	89,464

Within a ten mile radius from the center of in New Haven (in New Haven greater area in New Haven or region), the CTDHP dental network of providers is as follows:

Provider Type	Total #	Accepting New Clients
General		
Dentist	142	134
Pediatric		
Dentist	19	16
Specialists	41	34
Clinics	4	4
Dental		
Practices	96	90

For the above offices the average wait time for obtaining a routine appointment in is approximately 21.25 days.

¹ Network measurement as of December 31, 2010. The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! New London, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in New London, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider network of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater New London area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL	11,809	10,562	22,371

Within a ten mile radius from the center of New London, (greater New London area or New London region), the CTDHP dental network of providers is as follows:

Provider		
Туре	Total #	Accepting New Clients
General		
Dentist	20	19
Pediatric		
Dentist	6	0
Specialists	5	6
Clinics	1	1
De ntal		
Practices	18	16

For the above offices the average wait time for obtaining a routine appointment is approximately 35 days.

¹ Network measurement as of December 31, 2010 . The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Stanford, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Stamford, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider network of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Stamford area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			46,053

Within a ten mile radius from the center of Stamford the CTDHP dental network of providers is as follows:

Provider Type	Total #	Accepting New Clients
General		
Dentist	71	67
Pe diatric		
Dentist	21	21
Specialists	29	29
Clinics	5	.5
Dental		
Practices	30	29

For the above offices the average wait time for obtaining a routine appointment is approximately 6 days.

¹ Network measurement as of December 31, 2010 . The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Stratford, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Stratford, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider net- work of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B, and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Stratford, area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			105,824

Within a ten mile radius from the center of Stratford the CTDHP dental network of providers is as follows:

Provider		
Ty pe	Total #	Accepting New Clients
General		
Dentist	147	135
Pe diatric		
De ntist	27	27
Specialists	55	55
Cl inies	5	5
Dental		
Practices	93	87

For the above offices the average wait time for obtaining a routine appointment is approximately 6 days.

¹Network measurement as of December 31, 2010 . The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Torrington, Connecticut

Today. according to the Connecticut Department of Social Services (DSS) any child in Torrington, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider net- work of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A. HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Torrington area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			17,312

Within a ten mile radius from the center of Torrington the CTDHP dental network of providers is as follows:

Provider		
Туре	Total #	Accepting New Clients
Ge neral		
De ntist	20	16
Pediatric		
Dentist	3	3
Specialists	5 .	5
Clinies	1	1
Denta		
Practices	24	21

For the above offices the average wait time for obtaining a routine appointment is approximately 3 days.

¹ Network measurement as of December 31, 2010. The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Waterbury, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Waterbury, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider network of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Waterbury area during 2010 is as follows:

	Adults	Children	Total
	(>21)	(<21)	
TOTAL	31,179	29,222	60,401

Within a ten mile radius from the center of Waterbury (Waterbury greater area or Waterbury region), the CTDHP dental network of providers is as follows:

Provider Type	Total #	Accepting New Clients
General		
De ntist	79	69
Pediatric		
Dentist	2	2
Specialists	11	11
Clinics	2	2
Dental		
Pra ctices	48	46

For the above offices the average wait time for obtaining a routine appointment is approximately 7.7 days.

 $^{^1\,\}mathrm{Network}$ measurement as of December 31, 2010 . The next compilation will be performed in March 2012



CT Kids Have <u>Access</u> To Dental Care! More Need To Utilize It! Windham, Connecticut

Today, according to the Connecticut Department of Social Services (DSS) any child in Windham, Connecticut can receive an emergency dental appointment within 24 hours and a routine dental visit within 2 weeks. This is in large part thanks to the 1,300+ dental provider network of the Connecticut Dental Health Partnership (CTDHP), the oral health program for state residents who receive their health care from the DSS Medical Assistance Program. CTDHP serves more than 560,000 clients enrolled in HUSKY A, HUSKY B and Medicaid. Approximately half are children.

The number of enrolled CTDHP members in the greater Windham area during 2010 is as follows:

	Adults (>21)	Children (<21)	Total
TOTAL			18,857

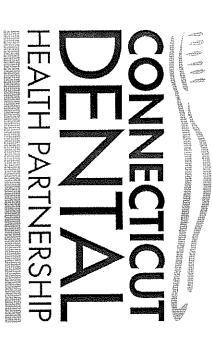
Within a ten mile radius from the center of Windham (greater area or region), the CTDHP dental network of providers is as follows:

Provider		
Type	Total #	Accepting New Clients
Ge neral		
De ntist	24	22
Pe diatric		
Dentist	1	0
Sp ecialists	6	6
Clinies	1	1
Dental		
Practices	11	10

For the above offices the average wait time for obtaining a routine appointment in approximately 17 day...

¹ Network measurement as of December 31, 2010. The next compilation will be performed in March 2012

Appendix G



November 2011



Participating Dental Practitioners as of November 30, 2011

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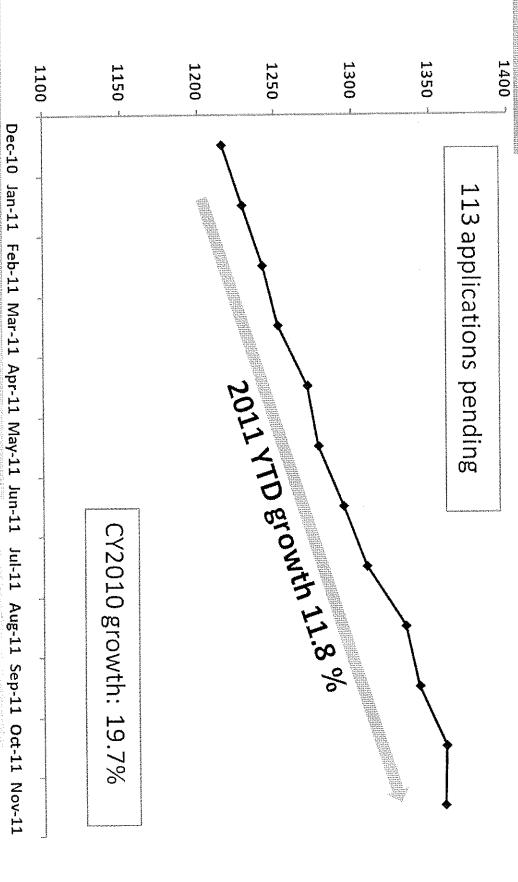


Participating Dental Service Locations as of November 30, 2011

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Participating Dental Practitioners as of November 30, 2011





dental services, please have them contact If you or your staff are contacted by a HUSKY or Medicaid client regarding the CTDHP call center.

866-420-2924

24 hours a day, 7 days a week

Appendix H

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Originating Council

Council on Clinical Affairs

Review Council

Council on Clinical Affairs

Adopted

2001

Revised

2004, 2008

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that unique clinical circumstances can result in challenges in restorative care for infants, children, adolescents, and persons with special health care needs. When circumstances do not permit traditional cavity preparation and/or placement of traditional dental restorations or when caries control is necessary prior to placement of definitive restorations, interim therapeutic restorations (ITR)1 may be beneficial and are best utilized as part of comprehensive care in the dental home.^{2,3} This policy will differentiate ITR from atraumatic/alternative techniques (ART)4 and describe the circumstances for its use.

Methods

This policy is based upon a review of current dental literature. A MEDLINE search was performed using key words "dental caries", "atraumatic restorative treatment", and "glass ionomer cement".

Background

Atraumatic/alternative restorative technique (ART) has been endorsed by the World Health Organization as a means of restoring and preventing caries in populations with little access to traditional dental care.4 In many countries, practitioners provide treatment in non-traditional settings that restrict restorative care to placement of provisional restorations. Because circumstances do not allow for follow-up care, ART mistakenly has been interpreted as a definitive restoration. ITR utilizes similar techniques but has different therapeutic goals. Interim therapeutic restoration more accurately describes the procedure used in contemporary dental practice in the US.

ITR may be used to restore and prevent further decalcification and caries in young patients, uncooperative patients, or patients with special health care needs or when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed.5,6 Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth.7

The use of ITR has been shown to reduce the levels of cariogenic oral bacteria (eg, mutans streptococci, lactobacilli) in the oral cavity.8-10

The ITR procedure involves removal of caries using hand or slow speed rotary instruments with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as self-setting or resin-modified glass ionomer cement.11 ITR has the greatest success when applied to single surface or small 2 surface restorations. 12,13 Inadequate cavity preparation with subsequent lack of retention and insufficient bulk can lead to failure. 12 Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations.

Policy statement

The AAPD recognizes ITR as a beneficial provisional technique in contemporary pediatric restorative dentistry. ITR may be used to restore and prevent dental caries in young patients, uncooperative patients, patients with special health care needs, and situations in which traditional cavity preparation and/or placement of traditional dental restorations are not feasible. ITR may be used for caries control in children with multiple carious lesions prior to definitive restoration of the teeth.

References

- 1. American Academy of Pediatric Dentistry. Clinical guideline on pediatric restorative dentistry. Pediatr Dent 2008; 30(suppl):163-9.
- 2. Nowak AJ, Casamassimo PS. The dental home. J Am Dent Assoc 2002;133(1):93-8.
- 3. American Academy of Pediatric Dentistry. Policy on the dental home. Pediatr Dent 2007;29(suppl):22-3.
- 4. Frenken J, Pilot T, van Amerongen E, Phantumvanit P, Songpaisan Y. Manual for the atraumatic restorative treatment approach to control dental caries, 3rd ed. WHO Collaboration. Centre for Oral Health Services Reseach. Groningen, The Netherlands; 1997.

- 5. Deery C. Atraumatic restorative techniques could reduce discomfort in children receiving dental treatment. Evid Based Dent 2005;6:9.
- 6. Gryst ME, Mount GJ. The use of glass ionomer in special needs patients. Aust Dent J 1999;44(4):268-74.
- 7. Vij R, Coll JA, Shelton P, Forooq NS. Caries control and other variables associated with success of primary molar vital pulp therapy. Pediatr Dent 2004;26(3):214-20.
- 8. Bonecker M, Grossman E, Cleaton-Jones PE, Parak R. Clinical, histological and microbiological study of hand-excavated carious dentine in extracted permanent teeth. SADJ 2003;58(7):273-8.
- 9. Carvalho CK, Bezerra AC. Microbiological assessment of saliva from children subsequent to atraumatic restorative treatment (ART). Int J Paediatr Dent 2003;13(3):186-92.
- 10. Wambier DS, dosSantos FA,Guedes-Pinto AC, Jaeger RG, Simionato MRL. Ultrastructural and microbiological analysis of the dentin layers affected by caries lesions in primary molars treated by minimal 88 intervention. Pediatr Dent 2007;29(3):228-34.

- 11. Yip HK, Smales RJ, Ngo HC, Tay FR, Chu F. Selection of restorative materials for the atraumatic restorative treatment (ART) approach: A review. Spec Care Dent 2001;21 (6):216-221.
- 12. Mandari GJ, Frencken JE, van't Hof MA. Six-year success rates of occlusal amalgam and glass-ionomer restorations placed using three minimal intervention approaches. Caries Res 2003;37(4):246-53.
- 13. Dulgergil CT, Soyman M, Civelek A. Atraumatic restorative treatment with resinmodified glass ionomer material: Short-term results of a pilot study. Med Princ Pract 2005;14(4):277-80.

Appendix I

Policy on workforce issues and delivery of oral health care services in a dental home

Originating Council
Council on Clinical Affairs

Adopted

2011

Purpose

The American Academy of Pediatric Dentistry (AAPD) advocates optimal oral health and health care services for all children, including those with special health care needs. Strategies for improving access to dental care, the most prevalent unmet health care need for disadvantaged US children, and increasing utilization of available services should include, but not be limited to, workforce considerations. This policy will address workforce issues with an emphasis on the benefits of oral health care services delivered within a dentist-directed dental home.

Methods

In 2008, the AAPD created a Task Force on Workforce Issues (**TFWI**) which was charged, in part, with investigating the problem of access to oral health care services by children in the US and analyzing the different auxiliary delivery systems available. The TFWI's findings and recommendations were summarized in a report¹ presented to the AAPD Board of Trustees in 2009. That report serves as the basis for this policy.

Background

Access to oral health care for children is an important concern that has received considerable attention since publication of *Oral Health in America: A Report of the Surgeon General*, in 2000.² The report identified "profound and consequential disparities in the oral health of our citizens" and that dental disease "restricts activities in school, work, and home, and often significantly diminishes the quality of life." It concluded that for certain large groups of disadvantaged children there is a "silent epidemic" of dental disease. This report identified dental caries as the most common chronic disease of children in the US, noting that 80 percent of tooth decay is found in 20-25 percent of children, large portions of whom live in poverty or low-income households and lack access to an ongoing source of quality dental care.

The mission of the AAPD, the membership organization representing the specialty of pediatric dentistry, is "to advocate policies, guidelines, and programs that promote optimal oral health and oral health care for infants and children through adolescence, including those with special health care needs." AAPD has long focused its efforts on addressing the disparities between children who are at risk of having high rates of dental caries and the millions of US children who enjoy access to quality oral health care and unprecedented levels of oral health. AAPD's advocacy activities take place within the broader health care community and with the public at local, regional, and national levels.

Access to care issues extend beyond a shortage or maldistribution of dentists or, more specifically, dentists who treat Medicaid or State Children's Health Insurance Program (CHIP) recipients. Health care professionals often elect to not participate as providers in these programs

due to low reimbursement rates, administrative burdens, and the frequency of failed appointments by patients whose treatment is publicly funded.⁴⁻⁷ Nevertheless, American Dental Association (ADA) survey data reveals that pediatric dentists report the highest percentage of patients insured through public assistance among all dentists.⁸ Especially when considering the disincentives of participating as Medicaid/CHIP providers, more dentists and/or non-dentist oral health care providers cannot be considered the panacea for oral health disparities.

Inequities in oral health can result from under-utilization of services. Lack of health literacy, limited English proficiency, and cultural and societal barriers can lead to difficulties in utilizing available services. Financial circumstances and geographical/transportational considerations also can impede access to care. Eliminating such barriers will require a collaborative, multifaceted approach.^{9,10} All the while, stakeholders must promote education and primary prevention so that disease levels and the need for therapeutic services decrease.

All AAPD advocacy efforts are based upon the organization's core values¹¹ which include:

- 1. Health and health care equity
- 2. An effective dental workforce
- 3. Effective public programs
- 4. Oral health promotion
- 5. Child and adolescent welfare
- 6. Science, education, research, and evidence-based care

A major component of AAPD's advocacy efforts is development of oral health policies and evidence-based clinical practice guidelines¹² that promote access to and delivery of safe, high quality comprehensive oral healthcare for all children, including those with special health care needs, within a dental home. A dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivery, in a comprehensive, continuously-accessible, coordinated, and family-centered way.¹³ Such care takes into consideration the patient's age, developmental status, and psychosocial well-being and is appropriate to the needs of the child and family. This concept of a dental home was detailed in a 2001 AAPD oral health policy¹⁴ and is derived from the American Academy of Pediatrics' (AAP) model of a medical home. 15,16 Children who have a dental home are more likely to receive appropriate preventive and therapeutic oral healthcare. The AAPD, AAP, ADA, and Academy of General Dentistry support the establishment of a dental home as early as 6 months of age and no later than 12 months of age.^{12,17,18} This provides time-critical opportunities to provide education on preventive health practices and reduce a child's risk of preventable dental/oral disease when delivered within the context of an ongoing relationship. Prevention can be customized to an individual child's and/or family's risk factors. Growing evidence supports the effectiveness of early establishment of a dental home in reducing early childhood caries.19,20 Each child's dental home should include the capacity to refer to other dentists or medical care providers when all medically necessary care cannot be provided within the dental home. The AAPD strongly believes a dental home is essential for ensuring optimal oral health for all children.

Central to the dental home model is dentist-directed care. The dentist performs the examination, diagnoses oral conditions, and establishes a treatment plan that includes preventive services, and all services are carried out under the dentist's supervision. This

delivery model implies direct supervision (ie, physical presence during the provision of care) by the dentist. The allied dental personnel [eg, dental hygienist, expanded function dental assistant/auxiliary (EFDA), dental assistant] work under direct supervision of the dentist to increase productivity and efficiency while preserving quality of care. This model also allows for provision of preventive oral health education by EFDAs and preventive oral health services by a dental hygienist under general supervision (ie, without the presence of the supervising dentist in the treatment facility) following the examination, diagnosis, and treatment plan by the licensed, supervising dentist. Furthermore, the dental team can be expanded to include auxiliaries who go into the community to provide education and coordination of oral health services. Utilizing allied personnel to improve oral health literacy could decrease individuals' risk for oral diseases and mitigate a later need for more extensive and expensive therapeutic services.

In addition to promoting quality oral health care through its policies and guidelines, AAPD advocacy efforts, in part, include:

- 1. Improving perinatal and infant oral health by training pediatric and general dentists to perform infant oral health examinations.
- Representing pediatric dentists on an advisory committee to the Bureau of Health Professions, promoting funding for pediatric and general dentistry residency programs and faculty loan repayment.
- 3. Conducting annual workshops which train pediatric dentists from across the country to educate legislators on strategies to improve access to pediatric dental care.
- 4. Working with the ADA to identify non-financial barriers to oral health care and develop recommendations to improve access to care for Medicaid recipients.^{21,22}
- 5. Partnering with the Office of Head Start to launch the "dental home initiative", engaging the dental community to develop a network of dental homes linked to Head Start facilities throughout the country.²³
- Utilizing a TFWI (2008-2009) to examine the various non-dentist (also known as midlevel) provider models that exist and/or are being proposed to address the access to care issues.

The AAPD Task Force reported that a number of provider models to improve access to care for disadvantaged children have been proposed and, in some cases, implemented following the Surgeon General's report.¹ At the heart of the issue with each non-dentist provider proposal is ensuring ongoing access to dental care for the underserved. Therefore, practice location and retention of independent non-dentist providers are important considerations. When providers are government employees, assignment to areas of greatest need is possible. However, the current US proposed models are private practice/non-government employee models, providing no assurances that independent providers will locate in underserved areas. Moreover, evidence from several developed countries that have initiated mid-level provider programs suggests that, when afforded an opportunity, those practitioners often gravitate toward private practice settings in less-remote areas, thereby diminishing the impact on care for the underserved.²4

In all existing and proposed non-dentist provider models, the clinician receives abbreviated levels of education compared to the educational requirements of a dentist. For example, the dental health aid therapist model in Alaska is a 2 year certificate program with a pre-requisite

high school education,²⁵ the educational requirement for licensure as a dental therapist in Minnesota is a baccalaureate or master's degree from a dental therapy program,²⁶ and proposed legislation for dental therapists in Vermont requires a 2 year curriculum including at least 100 hours of dental therapy clinical practice under the general supervision of a licensed dentist.²⁷ Building on their college education, dental students spend 4 years learning the biological principles, diagnostic skills, and clinical techniques to distinguish between health and disease and to manage oral conditions while taking into consideration a patient's general health and well-being. The clinical care they provide during their doctoral education is under direct supervision. Those who specialize in pediatric dentistry must spend an additional 24 or more months in a full time post-doctoral program that provides advanced didactic and clinical experiences.²⁸ The skills that pediatric dentists develop are applied to the needs of children through their ever-changing stages of dental, physical, and psychosocial development, treating conditions and diseases unique to growing individuals.

While most pediatric dental patients can be managed effectively using communicative behavioral guidance techniques, many of the disadvantaged children who exhibit the greatest levels of dental disease require advanced techniques (eg, sedation, general anesthesia).^{29,30} Successful behavior guidance enables the oral health team to perform quality treatment safely and efficiently and to nurture a positive dental attitude in the pediatric patient.³¹ Accurate diagnosis of behavior and safe and effective implementation of advanced behavior guidance techniques necessitate specialized knowledge and experience.

Studies addressing the technical quality of restorative procedures performed by non-dentist providers have found, in general, that within the scope of services and circumstances to which their practices are limited, the technical quality is comparable to that produced by dentists. 32,33 There is, however, no evidence to suggest that they deliver any expertise comparable to a dentist in the fields of diagnosis, pathology, trauma care, pharmacology, behavioral guidance, treatment plan development, and care of special needs patients. It is essential that policymakers recognize that evaluations which demonstrate comparable levels of technical quality merely indicate that individuals know how to provide certain limited services, not that those providers have the knowledge and experience necessary to determine whether and when various procedures should be performed or to manage individuals' comprehensive oral health care, especially with concurrent conditions that may complicate treatment or have implications for overall health. Technical competence cannot be equated with long-term outcomes.

The AAPD continues to work diligently to ensure that the dental home is recognized as the foundation for delivering oral health care of the highest quality to infants, children, and adolescents, including those with special health care needs. The AAPD envisions that many new and varied delivery models will be proposed to meet increasing demands on the infrastructure of existing oral health care services in the US. New Zealand, known for utilizing dental therapists since the 1920's and frequently referenced as a workforce model for consideration in the US, recently completed its first nationwide oral health status survey in over 20 years. Dental care is available at no cost for children up to 18, with most public primary schools having a dental clinic and many regions operating mobile clinics.³⁴ Overall, 1 in 2 children in New Zealand aged 2–17 years was caries-free. The caries rate for 5 year olds and 8 year olds in 2009 was 44.4% and 47.9% respectively.³⁵ These caries rates, which are higher than the US, United Kingdom, and Australia, help refute a presumption that utilization of non-

dentist providers will overcome the disparities. As technology continues to advance, proposed models may suggest dentist supervision of services outside the primary practice location via electronic communicative means rather than through direct observation. Health care already has witnessed benefits of electronic communications in diagnostic radiology and other consultative services. The AAPD encourages exploration of new models of dentist-directed health care services that will increase access to care for underserved populations. But as witnessed through the New Zealand oral health survey, a multi-faceted approach will be necessary to improve the oral health status of our nation's children.

Policy statement

The American Academy of Pediatric Dentistry remains steadfast in its core values and mission to address the disparities between children who lack access to quality oral health care and those who benefit from such services. AAPD believes that all infants, children, and adolescents, including those with special health care needs, deserve access to high quality comprehensive preventive and therapeutic oral health care services provided through a dentist-directed dental home. In the delivery of all dental care, patient safety must be of paramount concern.

AAPD encourages the greater use of expanded function dental assistants/auxiliaries and dental hygienists under direct supervision to help increase volume of services provided within a dental home, based upon their proven effectiveness and efficiency in a wide range of settings.³³⁻³⁹ The AAPD also supports provision of preventive oral health services by a dental hygienist under general supervision (ie, without the presence of the supervising dentist in the treatment facility) following the examination, diagnosis, and treatment plan by the licensed, supervising dentist.

The AAPD strongly believes there should not be a two-tiered standard of care, with our nation's most vulnerable children receiving services by providers with less education and experience, especially when evidence-based research to support the safety, efficiency, effectiveness, and sustainability of such delivery models is not available.

AAPD will continue its efforts to:

- Educate families, health care providers, academicians, community leaders, and partnered governmental agencies on the benefits of early establishment of a dental home.
- Forge alliances with legislative leaders that will advance the dental home concept and improve funding for delivery of oral healthcare services and dental education.
- 3. Expand public-private partnerships to improve the oral health of children who suffer disproportionately from oral diseases.
- 4. Encourage recruitment of qualified students from rural areas and underrepresented minorities into the dental profession.
- 5. Partner with other dental and medical organizations to study barriers to care and underutilization of available services.
- Support scientific research on safe, efficacious, and sustainable models of delivery of dentist-directed pediatric oral health care that is consistent with AAPD's oral health policies and clinical practice guidelines.

Furthermore, AAPD encourages researchers and policy makers to consult with AAPD and its state units in the development of pilot programs and policies that have potential for significant impact in the delivery of oral health care services for our nation's children.

References

- Hinson HP, Berlocher WC, Berg JH, et al. Report of the American Academy of Pediatric Dentistry's Task Force on Workforce Issues. Chicago, Ill: American Academy of Pediatric Dentistry; 2009.
- US Dept of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, Md: US Dept of Health and Human Services. National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
- 3. American Academy of Pediatric Dentistry. Mission Statement. Pediatr Dent. 2010;32(special issue):4.
- 4. Damiano PC, Brown ER, Johnson JD, Scheetz JP. Factors affecting dentist participation in a state Medicaid program. J Dent Educ 1990;54(11):638-43.
- 5. Morris PJ, Freed JR, Nguyen A, Duperon DE, Freed BA, Dickmeyer J. Pediatric dentists' participation in the California Medicaid program. Pediatr Dent 2004;26(1):79-86.
- Hughes RJ, Damiano PC, Kanellis MJ, Kuthy R, Slayton R. Dentists' participation and children's use of services in the Indiana dental Medicaid program and SCHIP: Assessing the impact of increased fees and administrative changes. J Am Dent Assoc 2005;136(4):517-23.
- 7. Berman S, Dolins J, Tang S, Yudkowsky B. Factors that influence the willingness of private primary care pediatricians to accept more Medicaid patients. Pediatrics 2002;110(2):239-48.
- 8. American Dental Association. 2009 Survey of Dental Fees. Chicago, III: American Dental Association; September, 2009.
- American Dental Association. Breaking down barriers to oral health for all Americans: The role of workforce. A statement from the American Dental Association. February 22, 2011. Available at:
 - "http://www.ada.org/sections/advocacy/pdfs/ada_workforce_statement.pdf". Accessed March 14, 2011.
- 10. Academy of General Dentistry. White paper on increasing access to and utilization of oral health care services. Available at:
 - "http://www.agd.org/files/newsletter/7025accesstocarewhitepaper7-31-08.pdf". Accessed March 14, 2011.
- 11. American Academy of Pediatric Dentistry. Core Values. Pediatr Dent. 2010;32(special issue):5-6.
- 12. American Academy of Pediatric Dentistry. American Academy of Pediatric Dentistry 2010-11 Definitions, Oral Health Policies, and Clinical Guidelines. Available at: "http://www.aapd.org/media/policies.asp". Accessed March 12, 2011.
- 13. American Academy of Pediatric Dentistry. Definition of dental home. Pediatr Dent 2010; 32(special issue):12.
- 14. American Academy of Pediatric Dentistry. Policy on dental home. Pediatr Dent 2001;23(suppl):10. Revised 2004.
- 15. American Academy of Pediatrics Ad Hoc Task Force on the Definition of the Medical Home. The medical home. Pediatrics 1992;90(5):774.
- 16. American Academy of Pediatrics. Preventive oral health intervention for pediatricians. Pediatrics 2008;122(6):1387–94.

- 17. American Dental Association. ADA Statement on Early Childhood Caries. 2000:454. Available at: "http://www.ada.org/2057.aspx". Accessed March 12, 2011.
- 18. Academy of General Dentistry. When should my child first see a dentist? Available at: "http://www.agd.org/public/oralhealth/Default.asp?IssID=296&Topic=C&ArtID=1186# body". Accessed March 12, 2011.
- 19. Savage MF, Lee JY, Kotch JB, Vann WF, Jr. Early preventive dental visits: Effects on subsequent utilization and costs. Pediatrics 2004;114(4):e418-23.
- 20. Lee JY, Bouwens TJ, Savage MF, Vann WF Jr. Examining the cost-effectiveness of early dental visits. Pediatr Dent 2006;28(2):102-5; discussion 192-8.
- 21. American Dental Association Council on Access, Prevention, and Interprofessional Relations. Report on the June 23, 2008 Medicaid Provider Symposium. Chicago, III. Available at: "http://www.ada.org/sections/professionalResources/pdfs/topics_access_medicaid_sy
 - "http://www.ada.org/sections/professionalResources/pdfs/topics_access_medicaid_sy mposium.pdf". Accessed March 12, 2011.
- American Dental Association. Proceedings of the March 23-25, 2009 Access to Dental Care Summit. Chicago, Ill. Available at: "http://www.ada.org/sections/about/pdfs/access_dental_care_summit.pdf". Accessed March 12, 2011.
- 23. Providing Dental Homes for Head Start and Early Head Start Children. Reference #HHSP23320072912YC. Office of Management and Budget No. 0990-0115. Effective Date: September 30, 2007.
- 24. Satur J, Gussy M, Mariño R, Martini T. Patterns of dental therapists' scope of practice and employment in Victoria, Australia. J Dent Educ 2009;73(3):416-25.
- 25. Alaska Native Tribal Health Consortium. Alaska Dental Health Aide Therapist Initiative. Available at: "http://www.anthc.org/chs/chap/dhs/". Accessed April 7, 2011.
- 26. Minnesota Statutes 2008, section 150A.06, Subd.1d. Dental therapists. Available at: "http://www.dentalboard.state.mn.us/Portals/3/Licensing/Dental%20Therapist/DTLE G.pdf." Accessed March 13, 2011.
- 27. Vermont 2011 H.398. An act relating to the regulation of dental therapists. Available at: "http://www.scribd.com/doc/49762674/H-398-As-Introduced-Vermont-General-Assembly-via-MyGov365-com". Accessed March 13, 2011.
- 28. American Dental Association Commission on Dental Accreditation. Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry. 1998;23. Available at: "http://www.ada.org/sections/educationAndCareers/pdfs/ped.pdf". Accessed March 13, 2011.
- 29. Vargas CM, Ronzio CR. Disparities in early childhood caries. BMC Oral Health. 2006 Jun 15;(6 Suppl)1:S3. Available at: "http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2147596/?tool=pubmed". Accessed April 7, 2011.
- 30. Casamassimo PS, Thikkurissy S, Edelstein BL, Maiorini E. Beyond the dmft: The human and economic cost of early childhood caries. J Am Dent Assoc 2009;140(6):650-7.
- 31. American Academy of Pediatric Dentistry. Guideline on behavior guidance or the pediatric dental patient. Pediatr Dent 2010;32(special issue):147-55.
- 32. Ryge G, Snyder M. Evaluating the quality of dental restorations, J Am Dent Assoc 1973;87:369-377.
- 33. Scott Wetterhall S, Bader JD, Burrus BB, Lee JY, Shugars DA. Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska Final Report. 2010. Available at:

- "http://www.wkkf.org/~/media/F2E86B5717174D2E9311359902DF7216.ashx". Accessed March 13, 2011.
- 34. Gillies A. NZ children's dental health still among worst. The New Zealand Herald. March 6, 2011. Available at: "http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10710408". Accessed

March 14, 2011.

- 35. New Zealand Ministry of Health. Age 5 and year 8 oral health. In: Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey. New Zealand, 2010. Available at: "http://www.moh.govt.nz/moh.nsf/Files/oralhealth-statistics/\$file/age5-year8-oralhealth-data-from-school-dental-services-2009-v2.xls". Accessed March 14, 2011.
- 36. Luciano JW, Rothfuss LG, Von Gonten AS. The expanded function dental assistant training program. US Army Medical Department Journal, 2006:Jan-Mar. Available at: "http://findarticles.com/p/articles/mi_m0VVY/is_2006_Jan-March/ai_n17213723/". Accessed April 6, 2011.
- 37. Beazoglou T, Brown LJ, Ray S, Chen L, Lazar V. An Economic Study of Expanded Duties of Dental Auxiliaries in Colorado. American Dental Association, Health Policy Resources Center. Chicago, III; 2009. Available at: "http://www.ada.org/sections/professionalResources/pdfs/topics_economic_prod-2009.pdf". Accessed April 6, 2011.
- 38. Brearley Lj, Rosenmblum FN. Two-year evaluation of auxiliaries trained in expanded duties. J Am Dent Assoc 1972;84(3):600-10.
- Lotzkar S, Johnson DW, Thompson MB Experimental program in expanded functions for dental assistants: Phase 3 experiment with dental teams. J Am Dent Assoc 1971;82(5):1067-81.